		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT	IPLE CONSTRUCTI	ION	(X3) DATE SU COMPLE	
NVS3171AGC			B. WING _	-	1. O	11/0	5/2008	
			STREET ADD	RESS, CITY,	STATE, ZIP CODE	100	20	, <u></u>
				UNTERS BLUFF DRIVE I LAS VEGAS, NV 89030 QUENTE OF TOTAL				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORREC' PRECTIVE ACTION SHOP ERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
Y 000	Initial Comments			Y 000	y-000	)		
	a result of the Annu conducted at your f The facility is licens groups to provide c	Deficiencies was gen aal State Licensure s acility on November sed as a residential fa are for 6 elderly or d sons with mental illno	urvey 5, 2008. acility for isabled		A. Faei For SIX	lity is lice seven (7) (G).	zneed not	
	The findings and co	aplaints investigated. onclusions of any invon shall not be cons	estigation		,			
	prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  The following deficiencies were identified:		tions, y be ederal,					
Y 174	449.209(4)(a) Health and Sanitatio-Offensive odors		nsive	Y 174		lify was m		
	NAC 449.209 4. To the extent pra facility must be kep (a) Offensive odors		es of the		food)	which for	unch a unch a emp	e/roHa aut tie`d
	This Regulation is not met as evidenced by: Based on observation, the facility failed to ensure the premises were free from offensive odors.  Findings include:				mente Also scheo	vely /PRN col and n bed linem bute to c	was naked s ma hang	imple- schodu ke e ad
On 11/5/08 in the afternoon, there was a distinctly f deficiencies are cited, an approved plan of dorrection must be returned with			1/	10 days aff	ter receipt of this s		, v	PRN
ARODATOR		DEDICION IED DEDDECK	TATIVE CONT	ATURE		TITLE Owner	•	(X6) DATE /

ZWBI11

Bureau of Licensure and Certification

STATE FORM

Bureau of Licensure and Certification

STATEMENT	OF	<b>DEFICIENCIES</b>
AND PLAN OF	F C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

NVS3171AGC

A. BUILDING B. WING \_\_\_

11/05/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## A PRECIOUS GEMS ADULT CARE

1733 HUNTERS BLUFF DRIVE NORTH LAS VEGAS, NV 89030

A PRECIO	OUS GEMS ADULT CARE	ORTH LAS VEGAS,	NV 89030
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
Y 174	Continued From page 1 offensive urine odor throughout the facility. On 11/5/08 in the afternoon, there was a strodor of rotten food and waste in the kitcher dining room.	rong	Cont Fr. pg 2 Y174 also purchased Air purifier to Frashen up the air Make sure facility /premises must be kept from appensive oder. The Adm
Y 445	Severity: 2 Scope: 3 449.229(10) Exit doors	Y 445	nistrator /Owner will continue to monitor for compliance 01/20/09.
	NAC 449.229 10. An exit door in a residential facility must be equipped with a lock which requires a kee open it from the inside unless approved by State Fire Marshall or his designee.	ey to	Y 445: A. Exit Door B. Front Door (MAIN ENTRY)
	This Regulation is not met as evidenced by Based on observation, the facility failed to e that 1 exit door was not equipped with a loc which requires a key to open it from the instructional Findings include:	ensure ck	- As above mentioned was been fixed according appropriately w/c is keyle to open outside w/e is not
	On 11/5/08 in the afternoon, the front door equipped with a lock which required a key t unlock it from the inside.		outside. The Administrate Owner will continue tomon for for compliance.
	Severity: 2 Scope: 1		01/20/09.
Y 885	449.2742(9) Medication / Destruction	Y 885	
	NAC 449.2742 9. If the medication of a resident is disconti the expiration date of the medication of a rehas passed, or a resident who has been		
f deficiencies	s are cited, an approved plan of correction must be rete	urned within 10 days of	tor receipt of this statement of deficiencies

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

6899

ZWBI11

If continuation sheet 2 of 6



Bureau of Licensure and Certification				TORWAPPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NVS3171AGC			B. WING _		11/05/2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE	
A PRECI	OUS GEMS ADULT C	ARE		TERS BLUI AS VEGAS,		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE	
Y 885	medication, an empshall destroy the method of destructivitness and note the medication in the results or other condeemed to be an adestruction of medications of medications for the medication	e facility does not classed a residential edication, by an accesson, in the presence of the destruction of the ecord maintained purushing contents of viatainers into a toilet sicceptable method of cation.  Inot met as evidence for, the facility failed or 1 resident were not demitted 3/5/03. On 12 nedication bucket for Illowing expired medical	I facility eptable of a suant to als, hall be  I/5/08 in Resident cations:	Y 885	A. Resident # 2  - Vitasmart exp  - Promethazino  Syrup exp G  Resident # 2 for  oware/notified  ASAP according  ordered. Also  decertion expui  w/c is flucted  recorded / with  Administrator /  continue for  Oi/20/09	nily was mode, to replace per Pul as the soid mei- ed was dires at toiled wa tnessed. The
Y 898	449.2744(1)(b)(4) N	Medication / MAR		Y 898		
	NAC 449.2744					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

ZWBI11

If continuation sheet 3 of 6

RECEIVED

JAN 2 0 2009

Bureau of Licensure and Certification

<b>STATEMENT</b>	OF	<b>DEFICI</b>	<b>ENCIES</b>
AND PLAN OF	F C	ORREC	TION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

NVS3171AGC

A. BUILDING B. WING\_

11/05/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1733 HUNTERS BLUFF DRIVE

A PRECIOUS GEMS ADULT CARE		1733 HUNTERS BLUI NORTH LAS VEGAS,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETE DATE
Y 898	1. The administrator of a residential facility provides assistance to residents in the administration of medication shall maintain (b) A record of the medication administere each resident. The record must include:  (4) Instructions for administering the medication to the resident that reflect the corder or prescription of the resident's physical maintain an accurate record of medication administration for 1 of 5 residents (Reside Findings include:  Record Review  Resident #3 was admitted 3/5/03. The medication administration for Resident #3 contained Lisinopring includes.	n: ed to  current sician.  by: to nent #3).	1. Racident #3.  Lisinoprilooma Podacha was corrected / transcribed oppropriately. And will maintain / follow per instruction for administering the medication to the rasi dent that raplact the current order or prescription of the Resident physician. The Administration to 1 Continue tomonitor for compliance.
:	mg daily, ordered 11/3/08. The Medication Administration Record for November, 200 Lisinopril, 10 mg daily.  Severity: 2 Scope: 1		01/20/09.
	Repeat Deficiency: 7/12/07		
Y 922	449.2748(3)(a) Medication Labeling	Y 922	RECEIVED
If definions:	NAC 449.2748 3. Medication, including, without limitation, over-the-counter medication or dietary supplement, must be: s are cited, an approved plan of correction must be re-		JAN 2 2009  BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

PRINTED: 01/02/2009 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS3171AGC 11/05/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1733 HUNTERS BLUFF DRIVE A PRECIOUS GEMS ADULT CARE NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 922 Continued From page 4 Y 922 Y 922 (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the A. Resident #1 name of the prescribing physician. B. Resident #2 C. Resident 43 This Regulation is not met as evidenced by: D. Rose dent #4 Based on observation, the facility failed to ensure that medications for 4 of 5 residents were plainly All medication bottle labeled with the names of the resident and the prescribing physician (Resident #1, #2, #3, #4). was plainly labeled as Findings include: to ite contante, the name Resident #1

Resident #2

physician's name.

Resident #2 was admitted 3/5/03. On 11/5/08 in the afternoon, the medication bucket for Resident #2 contained the following medications which were not labeled with the resident's name and the physician's name:

Resident #1 was admitted 8/23/07. On 11/5/08 in

the afternoon, the medication bucket for Resident #1 contained a bottle of Pain Reliever, which was not labeled with the resident's name and the

Garlic Pure, 500 mg Vitamin E Aspirin Calcium, 500 mg Pain Reliever

Resident #3

it is prescribed and the name of the prescribing physician. The Administra. tor / Owner will continue to monitor for compliance 01/20/09 RECEIVED

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

SUREAU OF LICENSURE AND CERTIFICATION

LAS YEGAS, NEVADA

PRINTED: 01/02/2009 FORM APPROVED

Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING **NVS3171AGC** 11/05/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1733 HUNTERS BLUFF DRIVE A PRECIOUS GEMS ADULT CARE NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 922 Y 922 Continued From page 5 Resident #3 was admitted 3/5/03. On 11/5/08 in the afternoon, the medication bucket for Resident #3 contained the following medications which were not labeled with the resident's name and the physician's name: (2) Containers - A thru Z Vitamins Aspirin, 81 mg Resident #4 Resident #4 was admitted 9/21/07. On 11/5/08 in RECEIVED the afternoon, the medication bucket for Resident #4 contained the following medication which was JAN 2 0 2009 not labeled with the resident's name and the physician's name: BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA Aspirin, 81 mg Severity: 2 Scope: 3

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.